Patient Questionnaire/Medical History Form

Under Medicare and the state practice acts, we are required to obtain a complete medical history on all patients. This information is protected under HIPAA. Please answer all questions to the best of your ability.

Last Name: ________________________________ First Name: __________________________ M.I._____ Date: _____/____/_____

DOB: _____/____/_____ Age: _______ Sex: M / F **Hand Dominance**: R / L Height: _______Weight: _______

How did you hear about us? ____

Primary Care Doctor: ______________________________________ Referring Doctor: ____________________________________

If accident, please circle where the incident occurred: **HOME AUTO WORK PORTS OTHER** Next Doctors visit: ___/___/___

Occupation: _______________________________ Work involved: _______________________ Current Work Status:____________

Do you have any lifting restrictions? Y / N Do you live alone? Y / N Are there stairs where you live? Y / N

What is the reason for your visit today? ____

Briefly describe how your problem began: ____

What goals would you like to achieve through therapy? ____

Date of onset/injury: ___/___/___ Date of Surgery___/___/___ Type of Surgery: ____________________________

Treatments for your current chief complaint include: (circle all that apply)

No Treatment Yet	Physical Therapy	Chiropractic Care	Pain Management	Mechanical Traction
Massage	Injections	Aquatic Therapy	Brace/Tape	Surgical Intervention
Personal Training	Athletic Training	Other: _______________________		

Have any diagnostic tests been performed for this problem? (circle all the apply)

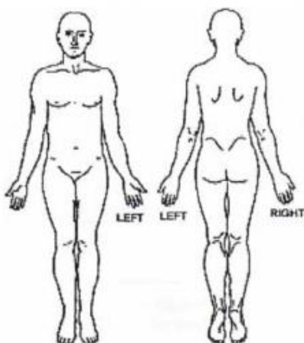
X-rays Bone Scan Doppler Ultrasound MRI EMG CT Scan Bloodwork Other: _______________

Please list body part tested and date tested: ____

Have you had similar symptoms in the past? Y / N Have you received Home Health PT prior to coming here? Y / N

Please Circle Where You Hurt: Where did your pain start? ____

Since it started, pain is: ___getting worse ___improving ___the same



Describe the pain: ___sharp ___dull ___aching ___sore ___throbbing

___cramping ___burning ___shooting ___stabbing ____squeezing

___constant ___intermittent ___other

What makes it worse? ____

What makes it better? ____

Does time of day affect pain? Y / N **Does pain wake you from sleep?** Y / N

Please rate your pain on 0-10 scale (0 no pain, 10 is the worst pain you can imagine):

Least: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Present: 0 1 2 3 4 5 6 7 8 9 10

Do you have any tingling or numbness or loss of sensation? Y / N If so, where? ____

Do you have any weakness? Y /N If so, for how long? ____

Do you have any swelling? Y / N If so, where? ____

Have you fallen two or more times within the past 12 months? Y / N

Do you use any of the following? Cane Walker Crutches Wheelchair

How would you rate your current health? _____excellent _____very good _____good _____fair _____poor

Please circle yes or no if you've had the following conditions:

Condition	Y / N	Condition	Y / N	Condition	Y / N
High Blood Pressure		Diabetes		Osteoarthrosis	
High Cholesterol		Heart Attack		Rheumatoid Arthritis	
Bowel/Bladder Dysfunction		Cardiac Bypass		Osteoporosis or Osteopenia	
Acid Reflux or Ulcers		Cardiac Stents		Scoliosis	
Thyroid disorder		Angina/ Chest Pains		Headaches or Migraines	
Bleeding disorder		Hepatitis		Dizziness or Fainting	
Seizures/Epilepsy		Emphysema		Cancer (Site:)	
Lyme Disease		COPD		Recent Infection	
Currently pregnant # of weeks?		Asthma		Multiple Sclerosis	
Fibromyalgia		Kidney Disease		Congestive Heart Failure	
Lupus		Stroke		Depression	

Please circle any that you may have/wear: Glasses Contacts Dentures Pacemaker Metal Implant Hearing aides

List all previous surgeries and dates in the last 5 years: ____

____

____

List all medications/ supplements you are taking including dosage and frequency: ____

____

____

List all allergies that you have: ____

Who should we call in case of an emergency?

Name: ___________________________________ Relationship: ___________________________ Phone: (______)______-________________

To the best of my ability, I have given and included all pertinent medical information

Patient/Guardian signature: ____ Date: ______/____/______

Medical History reviewed by physical therapist and used in determining the pain of care

Therapist signature: ____ Date: _____/____/_____

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